Bureau of Health Care Quality & Compliance

POC approved Amatrelle 8/10/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS468ASC	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS VEGAS REGIONAL SURGERY CENTER, L	3560 E FLAMINGO ROAD STE 105 LAS VEGAS, NV 89121

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 00	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a Life Safety Code and State Health Licensure re-survey conducted in your facility on 6/24/09 and finalized on 6/29/09, in accordance with Nevada Administrative Code, Chapter 449, Surgical Centers for Ambulatory Patients. The facility was surveyed following the 2006 edition of the American Institute of Architects (AIA), Guideline for the Design and Construction of Health Care Facilities and the 2006 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code. A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.	A 00		
A 02 SS=C	NAC 449.9795 ADMINISTRATION The governing body shall: 1. Adopt a set of rules which include provisions concerning: (a) the criteria by which the members and officers of the governing body are selected, their terms of	A 02		

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If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Margaret Arnett RN — TITLE: Director of Nursing — (X6) DATE: 30 July 2009

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A 02	Continued From page 1 office and their duties; (b) The frequency of its meetings; and (c) The annual revision and approval of the rules by the governing body. This Regulation is not met as evidenced by: Based on review of the Governing Body manual record provided by the center and interview the center failed to ensure by-laws were established and a set of rules were adopted. The Governing Body manual provided failed to contain a set of rules as specified in NAC 449.9795 including: 1. Criteria by which members are selected 2. Frequency of meetings 3. Annual revisions and approval of rules 4. Arrangement for minutes to be taken and dispensed to members Severity: 1 Scope: 3	A 02	A02 page 2 Governing Body bylaws have been established and will be approved by the Governing Body by July 31, 2009. The bylaws include: the criteria by which members are selected, the frequency of meetings, assigning responsibility to develop, approve and annually review policies, bylaws and rules, and provides for minutes to be taken and distributed to Governing Body members. The Governing Body Chairman is responsible for ensuring that the meetings are to take place with minutes taken and distributed. The Director of Nursing is responsible for maintaining a calendar or all meetings of the Governing Body and Committees and will schedule the meetings in advance. Patient safety was not directly effected by this deficiency. 07/31/09	
A 10 SS=C	NAC 449.980 Administration The governing body shall ensure that: 7. The center adopts, enforces and annually reviews written policies and procedures required by NAC 449.971 to 449.996, inclusive, including an organization chart. These policies and procedures must: (a) Be approved annually by the governing body. This Regulation is not met as evidenced by: The Governing Body failed to ensure the center adopted, enforced and annually reviewed written policies and procedures, as per NAC 449.971 - 449.996.	A 10	A10 Page 2 The Governing Body will develop, implement and approve a complete and current policy and procedure manual by August 14, 2009. The existing manual will be reviewed, revised and amended and include a signature page whereby the Governing Body Chairman signs that the Policies & Procedures Manual is annually reviewed and approved. The policies are being reviewed in consideration of all State regulations and revisions, corrections and additions are being made and will be completed by August 15, 2009. The Director of Nursing is responsible for spearheading the manual revisions with the assistance of the Center's clinical, administrative and medical staff. A checklist for Governing Body minutes has been created by the Director of Nursing and includes a reminder to review and approve the manual and all its policies which will ensure that this task be completed annually. Patient safety was not directly affected by this deficiency. 08/14/09	

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A 10	Continued From page 2 1. There was no documented evidence the Governing Body adopted and approved the policies and procedures. 2. There was no documented evidence the Governing Body reviewed and approved the policies and procedures on an annual basis. 3. There was evidence not all policies and procedures reflected compliance with state regulations. Severity: 1 Scope: 3	A 10		
A 59 SS=C	NAC 449.9812 Program for Quality Assurance 2. The program for quality assurance must include, without limitation: (a) Periodic reviews of the clinical responsibilities and authority of the members of the staff. (b) Periodic evaluations of members of the staff that are conducted by their peers. This Regulation is not met as evidenced by: Based on record review and interview the facility failed to ensure the quality assurance program included a periodic peer review. Severity: 1 Scope: 3	A 59	A59 Page 3 The peer review policy was reviewed and revised to require that peer review be performed on, at least, a semi-annual basis. The Director of Nursing, who acts as the QI Coordinator, is responsible for ensuring that the peer review takes place on a semi-annual basis. The Director of Nursing will utilize a calendar to act as a reminder of the need for QI activities. The Quality Improvement Committee is responsible for appointing qualified physicians to perform the peer review and has done so as of 2008. The physicians performing peer review were contacted by the Director of Nursing and reminded of their participation in the Center's QI Program. A reasonable sampling of medical records was chosen from the previous six months and peer review will be performed by August 14 with the results being forwarded to the Quality Improvement Committee for review by August 31, 2009. Patient safety potentially could have been affected by the lack of peer review and patient safety continues to be monitored through other QI activities and will improve with the addition of regular peer review activity.	08/31/09
A 66 SS=F	NAC 449.9812 Program for Quality Assurance 2. The program for quality assurance must include, without limitation: (g) Procedures for identifying and addressing any problems or concerns related to the care provided to patients using the medical records of the center and any other sources of data that may be useful to identify previously unrecognized	A 66		

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A 66	Continued From page 3 concerns, and for assessing the frequency, severity and sources of suspected problems and concerns. The procedures must include, without limitation, procedures for assessing: (3) The procedures used to control the quality of radiological, pathological, laboratory and pharmaceutical services provided by the center. This Regulation is not met as evidenced by: Based on pregnancy testing log review and interview the facility failed to ensure procedures were in place for quality control testing to be done on the pregnancy testing machine prior to use for patients. Severity: 2 Scope: 3	A 66	A66 Page 4 The Director of Nursing has created and implemented a policy, procedure, log and competency for the pregnancy testing machine as of July 20, 2009. The Governing Body has approved the policy, procedure, competency and log as of July 20, 2009. An Inservice was held with all clinical staff prior to implementation of the log and competencies were performed prior to July 20, 2009. Patient safety, potentially, could have been affected but no untoward results occurred. To prevent any compromise to patient safety, each nurse will be evaluated for their competency with the pregnancy machine within 10 days of hire. The Director of Nursing will perform the evaluation on an ongoing basis to ensure quality care.	07/20/09
A100 SS=F	NAC 449.983 Protection from Fires and Other Disasters 1. The administrator shall ensure that the center, members of the staff and patients are adequately protected from fire or other disasters. He shall prepare a written plan describing all actions to be taken by the members of the staff and patients in the case of any such incident. This plan must be approved by the governing body and the local fire department and must include provisions for: (g) The conduct of fires drills not less frequently than once each quarter for each shift of employees and requirements for a dated, written report and an evaluation of each drill. This Regulation is not met as evidenced by: Based on record review and interview the center failed to conduct fire-drills, no less than once each quarter, and failed to complete a written evaluation of the required fire-drills. The center's policy stated fire-drills would be conducted on a monthly basis.	A100	A100 Page 4 The Director of Nursing and Administrator reviewed and revised the Fire Drill policy to state that fire drills will be performed quarterly and emergency drills annually. The policy was completed, submitted to the Governing Body and approved as of July 20, 2009. An Inservice will be held with all staff regarding fire emergencies by July 31, 2009. The Director of Nursing is responsible for ensuring that drills are performed according to policy and state regulation utilizing a calendar to schedule these events. Patient safety, potentially, could have been affected but no untoward incidents occurred as a result of this deficiency. The regular, periodic performance of Inservices and fire drills will increase patient safety.	07/31/09

Acceptable 8/14/09

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A100	Continued From page 4 There was no documented evidence fire drills were conducted. There was no documented evidence a written evaluation of each drill was conducted. Severity: 2 Scope: 3	A100		
A102 SS=F	NAC 449.983 Protection from Fire and Other Disaster 1. The administrator shall ensure that the center, members of the staff and patients are adequately protected from fire or other disasters. He shall prepare a written plan describing all actions to be taken by the members of the staff and patients in the case of any such incident. This plan must be approved by the governing body and the local fire department and must include provisions for: (i)A rehearsal and a review of the plan at least once each year with a separate rehearsal for other disasters at least once each year. A written report and evaluation of each rehearsal must be on file. This Regulation is not met as evidenced by: Based on interview and record review the facility failed to ensure a separate rehearsal for disasters was conducted and documented yearly. Severity: 2 Scope: 3	A102	A102 Page 5 The Director of Nursing and Administrator reviewed policy regarding emergency and disaster drills and confirmed that these drills are to be performed annually. An Inservice and drill will be held with all staff regarding identified potential disasters by July 31, 2009. The Director of Nursing is responsible for ensuring that drills are performed according to policy and state regulation utilizing a calendar to schedule these events. Patient safety, potentially, could have been affected but no untoward incidents occurred as a result of this deficiency. The regular, periodic performance of Inservices and disaster drills will increase patient safety.	07/31/09
A112 SS=F	NAC 449.9855 PERSONNEL 2. Each employee of the center must: (a) Have a skin test for tuberculosis in accordance with NAC 441A.375. A record of each test must be maintained at the center. This Regulation is not met as evidenced by:	A112		

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A112	Continued From page 5 Based on record review the facility failed to ensure the staff had Tuberculosis (TB) screening in accordance with NAC 441A.375 for 12 of 19 employees (Employees #1, 2, 3, 5, 7, 9, 11, 13, 15, 16, 18, 19). The facility's personnel files policy was not in compliance with NAC 441A.375. The policy revealed TB screening and employee physical were to be done within six months of hire. There was no evidence of a TB screening in accordance with NAC 441A.375 for Employees #1, 2, 3, 5, 7, 9, 11, 13, 15, 16, 18, and 19. Severity: 2 Scope: 3	A112	A112 Page 6 The Director of Nursing and Administrator have reviewed and revised the personnel policies to be in compliance with state regulations. The policies were reviewed, approved by the Governing Body and implemented as of July 28, 2009. The Business Office Manager is responsible for ensuring that all employee files are in compliance with policies and federal and state code. The Business Office Manager will have all employee and medical staff files complete, including TB screening, by August 31, 2009. A checklist has been created by the Business Office Manager and will be utilized to ensure that all employee files are complete. Patient safety, potentially, could have been affected but no untoward incidents occurred as a result of this deficiency. The initial, two step TB screening and annual follow-up screening will increase patient safety.	08/31/09
A113 SS=C	NAC 449.9855 Personnel 2. Each employee of the center must: (b) Within 10 days after the date of his employment, and periodically thereafter, be instructed in the control of infections, the prevention of fires, the safety of the patients, preparation in case of disaster, and the policies and procedures of the center. This Regulation is not met as evidenced by: Based on record review and interview the facility failed to ensure employees were instructed in the control of infectious diseases, the prevention of fires and disaster, and the safety of patients within 10 days of employment for 7 of 10 employees (Employees #1, 2, 3, 5, 6, 7, 9, 10). Severity: 1 Scope: 3	A113	A113 Page 6 The Director of Nursing and Administrator have created an Orientation Checklist for new hires that was completed, approved by the Governing Body and implemented as of July 28, 2009. Inservices will have been directed by the Director of Nursing and completed as of July 31, 2009 with all current staff to ensure they have been instructed in the control of infections, the prevention of fires, the safety of patient, disaster preparations and the policies and procedures of the Center. The Director of Nursing is responsible for ensuring that all employees receive appropriate instruction	
A171 SS=C	NAC 449.992 Pathological Services	A171		

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A171	Continued From page 6 1. Pathology services must be provided by a staff pathologist or by a pathologist used as a consultant by the ambulatory surgical center. The pathologist must be licensed to practice in this state. This Regulation is not met as evidenced by: Based on record review and interview the center failed to ensure pathology services were provided by a licensed staff or consultant pathologist. Severity: 1 Scope: 3	A17'	within 10 days of hire. Patient safety, potentially, could have been affected but no untoward incidents occurred as a result of this deficiency. Complete orientation of all staff in the control of infectious diseases and all other safety measures will maintain patient safety. A171 Page 7 The Director of Nursing has renewed an agreement with a local, licensed, Medicare certified pathologist to perform pathology services for the Center. The agreement will be approved by the Governing Body on or before August 14, 2009 and a site visit performed by August 31, 2009. All agreements with ancillary providers will be reviewed annually by the Governing Body utilizing a checklist created by the Director of Nursing and Administrator. The Governing Body is responsible for ensuring that a pathologist's services be retained continually. Patient safety, potentially, could have been affected but no untoward incidents occurred as a result of this deficiency. Patient safety will be maintained through additional monitoring of waived testing.	08/31/09
A173 SS=C	NAC 449.992 Pathological Services 3. A list of tissues that do not routinely require microscopic examination must be approved by a pathologist and made available to the laboratory and the members of the medial staff. This Regulation is not met as evidenced by: Based on policy and procedure review and interview the facility failed to ensure a list of tissues that do no routinely require microscopic examination was approved by a pathologist. Severity: 1 Scope: 3	A173		08/31/09
A234 SS=F	State and Local Laws NAC 449.9843 Compliance with standards of construction. 4. An ambulatory surgery center shall comply with all applicable: (a) Federal and state laws; (b) Local ordinances, including, without limitations, zoning ordinances; and (c) Life safety, environmental, health, building and fire codes. If there is a difference between state and local requirements, the more stringent requirements	A234	A173 Page 7 The Director of Nursing, Administrator and Consulting Pathologist have created a list of tissues exempt from pathologist's review and it will be approved by the Governing Body as of July 31, 2009. The Director of Nursing and Medical Director shall ensure that the list is maintained and in place continually and the Governing Body shall review the exempt list at least annually. Patient safety was not compromised as a result of this deficiency but ongoing oversight of a pathologist will assist in the Center maintaining a high level of patient safety.	07/31/09

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A234	Continued From page 7 apply. This STANDARD is not met as evidenced by: Your facility was surveyed using the 2006 edition of the National Fire Protection Association (NFPA) 101 Life Safety Code, Chapter 21 Existing Ambulatory Health Care Occupancies. 21.2.9 Emergency Lighting and Essential Electrical Systems 21.2.9.2 Where general anesthesia or life-support equipment is used, each ambulatory health care facility shall be provided with an essential electrical system in accordance with NFPA 99, Standard for Health Care Facilities, unless otherwise permitted by the following: (1) Where battery-operated equipment is provided and acceptable to the authority having jurisdiction (2) Where a facility uses life-support equipment for emergency purposes only NFPA 99 3-4.4.1 Maintenance and Testing of Essential Electrical Systems 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches 1 Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.	A234	A234 Page 9 - Generator - The Director of Nursing and Business Office Manager were inserviced on the use and testing of the generator and a full load, monthly test was performed and documented as of July 8, 2009. The Director of Nursing is responsible for ensuring that the required testing (visual and mechanical) is performed according to state and federal regulations. A calendar of required activities will be utilized as a reminder to ensure compliance on an ongoing basis. Patient safety was not compromised as a result of this deficiency but patient safety will be maintained through the weekly and monthly monitoring of the essential electrical system. Acceptable 8/11/09 Medical gas – The Director of Nursing has retained the services of medical gas certifying agency to certify the medical gas system. The certification will be completed by August 31, 2009. The Director of Nursing is responsible for ensuring that the system is continuously maintained in accordance with state and NFPA regulations on an ongoing basis and will utilize an activity calendar to ensure that the required certifications take place. Patient safety was not compromised as a result of this deficiency but patient safety will be maintained through the continuous maintenance of the medical gas system. Acceptable 8/11/09	7/31/09 8/31/09

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A234	Continued From page 8 Based on interview, the facility failed to test their essential electrical system. Interview with the Director of Nursing revealed that the facility had not tested the generator set monthly as required; however; a two hour load bank test had been performed on 4/28/09 by a contractor. 21.7.6 Maintenance and Testing. See 4.6.12 4.6.12 Maintenance, Inspection, and Testing 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or requirements developed as part of a performance-based design, or as directed by the authority having jurisdiction. Based on interview, the facility failed to maintain the medical gas system. Interview with the Director of Nursing revealed that she did not know when the medical gas system had been last certified. There was no documentation at the facility of when the last certification was performed. Severity: 2 Scope: 3	A234		
A9999	Final Comments	A9999		

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A9999	Continued From page 9 Adopted Regulation of the State Board of Health, LCB file number R096-08: Section 15: Each program for the prevention and control of infections and communicable diseases must include policies and procedures to prevent exposure to blood-borne and other potentially infectious pathogens, including, without limitation, policies and procedures relating to: 3. Safe injection practices to prevent the contamination of equipment used for injections and medication. Those policies and procedures must provide that a new sterile needle and new sterile syringe must be used for each patient and may not be used for more than one patient. 6. The infusion of intravenous medications. Those policies and procedures must provide that intravenous tubing and fluid bags or bottles must not be used for more than one patient. Based on policy and procedure review and interview the facility failed to ensure the policies and procedures included policies and procedures for: 1. A new sterile needle and new syringe must be used for each patient and may not be used for more than one patient. 2. Intravenous tubing and fluid bags must not be used for more than one patient. Section 16: 1. Each program for the prevention and control of infections and communicable diseases must include policies and procedures for single-dose vials which provide that a single-dose vial may be accessed only by using an aseptic technique. The policies and procedures must provide that: a) Each injection of a medication from a single-dose vial must be prepared in a clean, designated area where contamination by blood or	A9999	A9999 Section 15 Page 10 The Director of Nursing and Administrator have reviewed and revised the Center's policies regarding the proper use and disposal of sterile needles, syringes, IV tubing and fluid bags to comply with all appropriate state regulations. The policies will be approved by the Governing Body by August 14, 2009. The Director of Nursing, Administrator and Medical Director, as directed by the Governing Body, are responsible for ensuring that the Center's staff comply with all policies including regarding the single use of the above on an ongoing basis through observation and training. An Inservice will be held with all clinical staff by August 14, 2009. Patient safety was not compromised as a result of this deficiency as the staff follows the state standard in practice. Future unanticipated occurrences may be avoided due to the staff's familiarity with these written policies. 8/14/09 Section 16 The Director of Nursing and Administrator have reviewed and revised the Center's policies regarding the proper handling of single and multi-dose vials to comply with all appropriate state regulations. The policies will be approved by the Governing Body by August 14, 2009. The Director of Nursing, Administrator and Medical Director are responsible for ensuring that the Center's staff comply with all policies including use of single and multi-dose vials on an ongoing basis through observation and training. An Inservice will be held with all clinical staff by August 14, 2009. Patient safety was not compromised as a result of this deficiency as the staff follows the state standard in practice. Future unanticipated occurrences may be avoided due to the staff's familiarity with these written policies. 8/14/09	

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A9999	Continued From page 10 bodily fluid is unlikely to occur; (b) The medication in a single-dose vial not be used for more than one patient; (d) Any remaining medication in a single-use vial after its use must not be combined with any other medication or otherwise used for any other patients. 2. Each program for the prevention and control of infections and communicable diseases must include policies and procedures for multidose vials which provide that a multidose vial may be accessed only by using an aseptic technique. The policies and procedures must provide that: (e) A needle must not be left inserted in the cap of a multidose vial after its use. Based on policy and procedure review and interview the facility failed to ensure policies and procedures for single and multidose vials included: 1. Single dose vials must be prepared in a clean area where contamination is unlikely to occur. 2. The medication in single dose vials must not be used for more than one patient. 3. Any remaining medication in a single use vial must not be combined with other medication or otherwise used for any other patients. 4. A needle must not be left inserted in the cap of a multidose vial. Section 17: 3. The manufacturer's instructions for operating any sterilizer or performing any disinfection procedure must be located or posted near the equipment used for sterilization or disinfection. Based on observation and interview the facility failed to ensure the manufacturer's instructions for the Steris Autoclave were available near the equipment.	A9999	A9999 Section 17.3 Page 11 The Director of Nursing has obtained a copy of the manufacturer's instructions on the operation of the Steris autoclave and they are stored in the sterilization area as of July 15, 2009. The Director of Nursing is responsible for ensuring that Center retains manufacturer's instructions for operating the sterilizer and disinfection equipment on an ongoing basis. Patient safety was not compromised as employees were following the manufacturer's instructions. Patient safety will be maintained through the availability of the reference material. 07/15/09	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS468ASC	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS VEGAS REGIONAL SURGERY CENTER, L	3560 E FLAMINGO ROAD STE 105 LAS VEGAS, NV 89121

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A9999	Continued From page 11 Section 18: 1. Each ambulatory surgical center shall designate an employee or enter into a contract with a person to oversee and manage all aspects of the program for the prevention and control of infections and communicable diseases. 2. (a) Shall have completed specialized training in the prevention and control of the development and transmission of infections and communicable diseases. Based on personnel file review and interview the facility failed to ensure the Infection Control coordinator had completed specialized training in the prevention and control of the development and transmission of infections and communicable diseases. Severity: 2 Scope: 3	A9999	A9999 Section 18 Page 12 The Governing Body has assigned the Director of Nursing to serve as the Infection Control Coordinator as of July 31, 2009 and for the Director of Nursing to complete infection control training. The Director of Nursing has signed up for training and will complete the training by August 31, 2009. The Director of Nursing is responsible for maintaining continuing education in infection control techniques on an ongoing basis and shall report to the Governing Body. Patient safety was not compromised as a result of this deficiency but patient safety shall be maintained as a result of additional infection control training.	08/31/09